Illinois Department of Public Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3:		COMPLETED
		11 0047400	D. WING		•	С
		IL6015192	B. WING		. 0	09/23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AC	DRESS, CITY	STATE, ZIP CODE		
BROOK	DALE HOFFMAN EST	S GULF RD	ST GOLF R			
	CUMMADVOTA		N ESTATES			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	<b>ACTION SHOUL</b>	D BE COMPLETE
s 000	Initial Comments		S 000			
		2015 - No findings ion 30.710a), 330.720b),			0	
1	330.790a), 330.790c)1) and 330.4240a)					
S9 <b>99</b> 9	Final Observations		S9999			
To the control of the	Statement of Licensi	ure Violations				
	330.710a) 330.720b) 330.4240a)					
	procedures governing facility. The written pot be formulated with the administrator. The written followed in operating reviewed at least ann	ave written policies and g all services provided by the policies and procedures shall				
	Policies - No resident evaluation to be in ne admitted to or kept in Neither shall any such distinct part designates theltered care.  Section 330.4240 Abua An owner, licensee	use and Neglect , administrator, employee or I not abuse or neglect a		Attack Statement of L	nment A icensure V	iclusions

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

4VVQ11

	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		E SURVEY PLETED
		IL6015192	B. WING		1	C <b>23/2015</b>
	PROVIDER OR SUPPLIER  DALE HOFFMAN EST	S GOLF RD 2150 WE	DDRESS, CITY, S ST GOLF ROAN ESTATES, I			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
S9999	Continued From page	ge 1	S9999			
	Based on observation review, the facility far admission/discharge house residents in the had been assessed higher level of nursing. This applies to 3 of a reviewed for ADL's (pressure ulcers in the The findings included of the findings included of the findings included of the facility	I residents (R1,R3, R4) activities of daily living) and e sample of 4.  1, 2015 at 1:22 PM, during ity, R3 was laying in bed. A resent in R3's room. E5 echanical lift for R3, to get I, and place him in a wheelchair. R3 is unable to without the use of the as a facility-acquired coccyx that is cared for by  15 at 8:25 AM, E6 ant) and E7 (RA) transferred e high-back reclining echanical lift. E6 said R3 ut the use of the mechanical			<b>⋄</b>	
t f	while in bed or in the assistance with all of	pathing, dressing and				

CTATE	MENT OF DEFICIENCIES	(V4) 000)//000//000//00//				
	LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE	SURVEY
1 / 11 - 1		DENTI ICATION NOMBER:	A. BUILDING	•	СОМ	PLETED
				_		^
		IL6015192	B. WING		1	C
		1.200.0.2			09/2	23/2015
NAME	OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
PPO	OKDALE HOFFMAN EST	2150 WE	ST GOLF RO	PAD		
BROC	DINDALL HOFFINAN EST	HOFFMA	N ESTATES,	IL 60194		
(X4) I	D SUMMARY STA	TEMENT OF DEFICIENCIES			0000000000	
PREF	IX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION)		(X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH		COMPLETE DATE
				DEFICIENCY		
S9 <b>9</b>	99 Continued From pa	ce 2	S9999			
•	· ·	<u> </u>	29999			
	(RN-Registered Nu	rse/Health and Wellness				
	Director) said, "Whe	en R3 first came here, he was	and the same of th			
	able to be transferre	ed without the use of a				
	mechanical lift, and	did not need as much	ALCO OF PARK			
	assistance with eati	ng. He has declined				
	significantly. He is n	ow unable to get out of bed				
	by himself. R3's spo	ouse does not want to move				
	him to a nursing hor	me, she wants to keep him				
	here."					
		Torona				
	On September 23, 2	2015 at 12:32 PM, E6 and E7				
	transferred R3 from	the high-back reclining				
	wheelchair back to b	ped, using the mechanical lift.				
	E6 and E7 provided	incontinence care to R3.	vane			I
	Upon turning R3 to h	nis right side, a dressing was				
	observed adhered to	R3's coccyx area. A portion				
	of the dressing was	peeling away from R3's skin				1
	and a stage 2 pressu	ure ulcer was visible under				
	the dressing, on R3's	s coccyx. Two reddened				ĺ
	areas were also visit	ole on R3's right and left				
	gluteal folds. E6 said	d the redness was "probably				
	caused by the sling u	used with the mechanical lift."	Name of the last o		1.77	
	, ,	The state of the s	w			
	On September 22, 20	015 at 12:10 PM, R3 was in	WALL			1
	the dining room, seal	ted in the high-back reclining				İ
	wheelchair, being fed	pureed food for lunch by E6				1
	(RA). R3 was unable	feed himself.			Ì	1
		Processing				I
	On September 23, 20	015 at 8:30 AM, R3 was in	***************************************		The state of the s	1
	the dining room, bein	g fed a pureed breakfast by	J			ŀ
	E9 (RA). R3 was una	able to feed himself	more case		A MARY THE PARTY OF THE PARTY O	
	, , , , , , , , , , , , , , , , , , ,	To took minotif.	444			
	The facility's POS (nh	ysician's order sheet) dated			11 111111111111111111111111111111111111	
	September 1 2015 for	or R3 shows diagnoses that				-
	include: dementia, ar	thritis incontinence			OTTO A ANNUAL PROPERTY.	l
	aggressive frontal loh	e aphasia, pacemaker, and				1
	atrial fibrillation.	o aphasia, pacemaker, and				I
	atra nomation.	10000aha	Notice of the second			1
	R3's resident care ala	in dated hims 4, 2045				
	chous D2 is "tatal"	in dated June 4, 2015,	TO A COMMAND			1
	anows Ro is "totally co	onfused, is rarely or never	1			1

Illinois Department of Public Health

		NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION 3:	(X3) DATE	SURVEY
				A. BOILDING	*		C
*			IL6015192	B. WING		•	23/2015
Charleston Malore	NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
Opposite Agency	BROOK	DALE HOFFMAN EST	S GOLF RD 2150 WES	ST GOLF RO	DAD		
			HOFFMAI	VESTATES	, IL 60194		
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	S9 <b>9</b> 99	Continued From page	ge 3	S9999			:
		understood, is sever makes decisions, re to and from meals, a areas, requires physiceth/dentures, brus face, shaving, require continence needs, u requires assistance  The facility's bi-annudated June 4, 2015 f Information - totally cunderstood, few workinformation - severel makes decisions. District programme information - total de with dressing/self perequires two-person	rely impaired: never or rarely quires assistance for mobility activities, and/or common sical assistance with brushing hing hair, washing hands and res assistance with ses mechanical lift and				
	s v () fe C a fr s h do w Eige ob	e uses high-back reclea.  2.) On September 22 seated in a high-back was being fed a med RA). R4 appeared lead to the recent of the recent and E8 (RA) used a mount of the recent and E8 (RA) used a mount of the recent and E8 (RA) used a mount of the recent and E8 provided in the recent of the recent and E8 provided in the recent and E8	ining wheelchair.  2, 2015 at 12:00 PM, R4 was a reclining wheelchair, and hanically altered lunch by E6 ethargic and was unable to 15 at 12:48 PM, E6 (RA) nechanical lift to transfer R4 heelchair to the bed. E6 and he does not help with eed himself, or dress self. He is bedridden if we cannot get in and out of bed ace R4 was placed in bed, incontinence care to R4, by ence brief and cleaning the safe's buttocks. R4 was uring the incontinence care excoriation was seen on				

0

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STATEME	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA1	E SUBVEY	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			(X3) DATE SURVEY COMPLETED	
						С	
		IL6015192	B. WING		09	/23/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE			
ppOOK	DALE HOFFMAN EST	2150 WE	ST GOLF R				
BROOK	DALE NOFFWAN EST	3 GOLF RD	N ESTATES				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
S9999	Continued From page	ge 4	S9999				
	near R4's gluteal fol was applied to R4. using pillows and lef On September 23, 2	2015 at 8:45 AM, R4 was ically altered breakfast by E9					
The state of the s	diagnoses that include	tember 1, 2015 for R4 shows de: vascular dementia with on, disorganized behavior, ance.					
	shows, "staff transporequires two-person bathing/showering. Swater on and off, get shampooing hair, wa extremities and towe assistance with meal and/or assistive device soft-chopped diet. Rrarely/never understollanguage, mumbles. with brushing teeth/dwashing hands and fasit-to-stand mechanic	Staff to assist with turning ting in and out of shower, ishing upper and lower I drying. Requires is due to eating limitations ces; mechanical 4 is totally confused, and: staff interprets body R4 requires physical assist entures, brushing hair, ace, shaving. Uses cal lift for transfers.					
	R4 is "incontinent of because full assist with mechanical lift for transes a high-back recland hospice services.	nsferring during all transfers, ining wheelchair for mobility,					
r	<ol> <li>R1 is no longer in eview and interviews nformation:</li> </ol>	the facility. Closed record revealed the following	THE CONTRACT OF STATE				

CTATEME	NT OF DEFICIENCIES	Treath	<del></del>		<del></del>	
	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION		E SURVEY
, , , ,		ISENTA IOMINISTR.	A. BUILDIN	G:	COM	PLETED
						С
		IL6015192	B. WING		i .	23/2015
	PROVIDER OR SUPPLIER		<del></del>		031	23/2013
NAME OF	LUCAIDER OR SOFFLIER			, STATE, ZIP CODE		
BROOK	DALE HOFFMAN EST		ST GOLF R			
		HOFFMAI	N ESTATES	, IL 60194		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	۵i	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	REGULATORY OR I	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
1		THO MI SIMATION	TAG	CROSS-REFERENCED TO THE APPROF	'KIAI E	DATE
60000	Continued F	-				
59999	Continued From pa	ge 5	S9999			
	The POS for R1 dat	ed May 1, 2015 showed				
	diagnoses that inclu	ded: syncope, Parkinson's				
	disease, dementia a	and coronary artery disease.				
	Physical therapy not	es for R1 dated April 14,				
	2015 shows, "patien	t presents with poor dynamic				177
	transfers."	ds mechanical lift for				
	transfers.					
	The facility provided	a level of care assessment				
	completed on July 2	1, 2014. The level of care				
diggraph (Case	assessment shows t	he next assessment was due				
	on January 17, 2015	On September 23, 2015 at				
	1:40 PM, E2 (RN/He	alth and Wellness Director)				
	said a level of care a	ssessment was never				
	completed for R1 aft	er July 21, 2014. We missed				
, i	it, I take full responsi	bility for that. There is a care				
	plan dated February	1, 2015, but the information		á		
(	on the care plan was	based on the level of care				
	assessed back in Jul	y, 2014."				17.0
-	The feathers of the second					
ļ .	ne facility's resident	care plan for R1, dated				
r	eoruary 14, 2015 sr	nows R1 "Must use 4 person				
6	ransfors: use wheels	mechanical lift with any				
9	ransiers, use wrieer	chair. R1 requires personal sing and undressing,				
r	equires assistance to	evacuate, requires				
a	ssistance for mobilit	y to and from meals,			!	
a	ctivities, beauty short	and/or common areas,				
n	nechanical soft diet v	with nectar thick liquids as of			1	
J	une 23, 2015,  and 1	500 cc (cubic centimeters)				
† † †	uid restriction per da	y. Poor skin integrity: April			Alf Color	
2	6, 2015 crack, right <sup>a</sup>	4th toe, May 15, 2015				
Va	ascular ulcer right fo	ot 4th interspace. July 13				
20	015 left buttocks, Jul	y 20, 2015 pressure ulcer				
le	ft buttocks.					I
7-1	in a familia de 18 A				İ	***************************************
	ne racility's "Assisted	Living Open Area Flow				
- 51	ieet dated July 13,	2015 shows R1 had a	-			j

Illinois Department of Public Health

	ENT OF DEFICIENCIES IN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DAT	E SURVEY
1		IDENTIFICATION NOTIFICA	A. BUILDING	G;	COM	PLETED
		IL6015192	B. WING			C
NAME OF					1 09/	23/2015
NAME OF	PROVIDER OR SUPPLIER			, STATE, ZIP CODE		
BROOK	(DALE HOFFMAN EST	S GOLF RD	ST GOLF RO N ESTATES			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
S9 <b>99</b> 9	Continued From page	ge 6	S9999			
	long by 1 centimeter on the left buttocks. provider: communit cream applied. End	cer measuring 3 centimeters r wide by 0 centimeters deep Primary wound care y. Current treatment: barrier orsed to follow up getting an th and inform power of		o		
	interview and record R1's left buttocks pre (District Director of C (RN), E2 said on Jul' (LPN-Licensed Pracipressure ulcer and fi On July 13, 2015 at 2 an order from Z2 (MI facility's progress not 1:00 PM showed "Rehome health nurse the buttocks. Change Due meds given. All facility lacked docum was seen by the home 2015. On July 15, 20 idenitifed a Stage 2 p buttocks and a Stage right buttocks.	review of the timeline for review of the timeline for ressure ulcer, with E10 Clinical Services) and E2 y 13, 2015 at 5:00 AM, E11 tical Nurse) discovered R1's lled out the "skin flow sheet." 2:00 PM, the facility obtained D) for home health. The tes dated July 14, 2015 at resident alert. To be seen by his afternoon re: wound care d and kept dry this shift. In need attended to." The entation to show R1's wound he health nurse on July 14, 2015, the home health nurse ressure ulcer on R1's left of pressure ulcer on R1's				
**	health), provided by to 2015. On July 20, 20-documented on the fabuttocks pressure ulcoentimeters long by 9 centimeters deep. Moserosanguinous, yellotissue macerated, bru	w drainage. Surrounding ised, painful. Primary home health. Notified Z2				

Illinois Department of Public Health

	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	L/V2) DAT	TE OLITA	
AND PLAI	N OF CORRECTION	IDENTIFICATION NUMBER:	1			E SURVEY MPLETED	
			A. BUILDIN	G:	""		
						С	
		IL6015192	B. WING		09	/23/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE			
BROOK	DALE HOFFMAN FOT	04 50 1415	ST GOLF R				
BROOK	DALE HOFFMAN EST	a Gulf Ku		6, IL 60194			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	·			· · · · · · · · · · · · · · · · · · ·	
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5)	
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		COMPLETE DATE	
				DEFICIENCY)		NATIONAL DESCRIPTION OF THE PROPERTY OF THE PR	
S9 <b>99</b> 9	Continued From page	ge 7	S9999				
	regarding wound sta	atus dotorioration "					
	regarding would sta	atus deterioration.					-
in the state of th	The facility's interdis	sciplinary progress notes					
d to open a	dated July 20, 2015	at 12:30 PM for R1 shows					ı
	"resident wound to le	eft inner buttocks and close to					1
	groin area noted to b	be draining yellow with blood		*			١
	minimal and strong	odor noted. Residential Care					1
100	Coordinator and Res	sident Care Director called				**	1
10.0	over to look at woun	d. Also home health nurse				SE STATE OF THE SECOND	١
a a company	came in to assess.	Dressing done of wound,					1
	cleanser, pat dry, ap	plied wound gel and border				1	١
	rodness Also super	ed. Barrier cream applied to					I
k managar ga	noted to right heal \	ficial coloring of small area					ı
MANA	for heel protection ar	Wrapped with gauze around nd home health aware to					ı
	order boots Patient	and resident assistant					ı
	teaching done to be	put down after meals to		·			ı
Personal	relieve pressure and	repositioning too. Endorse					l
1	to next shift."	. 3					
_				1		S Add S server	l
And the second	The progress notes of	dated July 21, 2015 at 10:30				THE	l
1	AM showed Z3 (Adva	anced Practice Nurse) called				na nanoon	l
[	o update her on wou	ind stating she will come to				nick and or page	
,	visit resident today." /	At 12:20 PM "Z3 arrived and					l
	risited with resident.	Assessed wound with an					l
	progress peter show	hospital for treatment." The					
F	PM on July 21, 2015.	R1 left the facility at 4:00					l
	on daily 21, 2010.	Ababa and a same and a same and a same and a same and a same and a same and a same and a same and a same and a					
l	On September 23, 20	115 at 9:20 AM, Z2 (MD)					
s	aid R1 was hospitaliz	zed for a pressure ulcer that					ĺ
i d	leteriorated at the fac	cility. "There was a lot of					
S	lough and necrotic tis	ssue in there, and once the	-		i		
р	ressure ulcer was de	ebrided, R1 was found to					ĺ
h	ave a fairly advanced	d stage 3 to stage 4					
р	ressure ulcer, which	ultimately led to R1's					
d	emise. R1 had been	bedridden for quite some					
tir	me, and required ass	sistance with all mobility.			1 ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) (		
R	4 could not function	independently. Treatment	a de la company				
i ot	tne pressure ulcer v	vould have required a				ĺ	

STATEME	NT OF DEFICIENCIES	(V4) DD01//DD52/01/2017	T				
AND PLAN	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DAT	E SURVEY	_
1		IDENTIFICATION NUMBER:	A. BUILDIN	IG:	COM	PLETED	
			1			_	
		11 604 5400	B. WING _			С	
		IL6015192	J. WING _		09/	23/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	/, STATE, ZIP CODE			-
			ST GOLF F				
BROOK	DALE HOFFMAN EST:	3 GULF RU					
	OLD HANDY OFFI	***************************************	V ESTATE:	5, IL 60194			
(X4) ID PREFIX	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
TAG	REGULATORY OR LS	SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHO		COMPLETE	
			TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)	COPRIATE	DATE	
00000	0 // 1=	_		,		!	
S9 <b>9</b> 99	Continued From page	ge 8	\$9999				
	colostomy to divert	stool away from the pressure					
	ulcer plus surgical r	repair of the pressure ulcer,				# P P P P P P P P P P P P P P P P P P P	
	and a lengthy treatm	nent period. It is unfortunate,					
	but the pressure ulc	er ultimately led to his					
7 1 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	demise."	er ditimately led to his					
	donnoo.	79		and the second s			
	The facility's policy of	entitled "Admission/Discharge		E. A. S.			
	Criteria Policy-AL" w	hich "Applies to: Sheltered					
	Care-Illinois Effective	e date: June 1, 2010"					ı
Amount of the second	shows: "Dollar Data	il: 1. Admission Criteria.				The second second	
A Commence of the Commence of	The community may	admit and retain older adults					1
	who meet the following	ng criteria:d) Do not					١
	require 24-hour chille	ed nursing services except as				The state of the s	ı
	nermitted by state la	wg) Demonstrates ability					ı
*** ALC:	to hear full weight du	wg) Demonstrates ability					١
	include assistance of	ring transfers which may					1
	annroyed assistance of	walker or cane or other			Î		ı
	criteria. The commun	evices3. Discharge					
	esident based on the	nity may discharge a			and over the state of the state		ı
,	the community datases	following criteria:g.) If					ı
· f	unctional level been	mines that a resident's			A transmission		ı
4	he recident's soci-	dvanced or declined so that					ı
	he resident's needs o	carriot be met in the					ı
£.	community which may	y include any of the					I
- 10	chowing. I) Incontin	nence, where the resident					
++	he problem 2) I	rticipate in management of					ı
	ne problem. 2) IMM	obility, where the resident					ı
3	Cyunes total assistar	nce in exiting the building.					ĺ
3	n) Any origoing condi	tion requiring a two-person			II 1700		l
l G	ansfer and/or mecha	anicai litt device."					
	In Santamba- 22, CO	45 -10-05 414 (1 5 )					
1 2	rovided a server "	15 at 8:35 AM, the facility					l
þi	rovided a copy of the	requested resident					ĺ
C	ontract, outlining disc	narge criteria. The					
ui	ndated contract show	vs: "Upon less than				l	
ţw.	venty-one (21) days'	notice. In addition, we may			and the same of th	l	
tra	anster or discharge y	ou and terminate this				1	
CC	ontract with less than	twenty-one (21) days			A distribution of the state of	I	
WI	ritten notice:d. Re	evaluation and	1			l	
te	rmination. Please no	ote the following conditions.				ľ	
an	nong others, may lea	ad to a re-evaluation and				I	

STATEME	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 (2/0) 1 4 4 4 5			
	N OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULI	IPLE CONSTRUCTION	(X3) DAT	E SURVEY
1		IDEATH IOATION NOWINER.	A. BUILDIN	IG:	COM	IPLETED
		IL6015192	B. WING			С
<del> </del>		120013192	1		09/	23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	Y, STATE, ZIP CODE		
		0450 1155	ST GOLF F			
BROOK	DALE HOFFMAN EST:					
			N ESTATE:	S, IL 60194		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	OI OI	PROVIDER'S PLAN C	OF CORRECTION	/3/P3
PREFIX TAG	PEGLI ATORY OR L	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE A	CTION SHOULD BE	(X5) COMPLETE
IAG	NEGOLATORT OR LO	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO		DATE
				DEFICIE	NCY)	
S9 <b>99</b> 9	Continued From page	P ar	S9999			
			00000	9.70		
	termination of your r	esidency(xi) You are				
	bedridden."	, ,		OLD THE SECOND STATE OF TH		
1						***
-	330.710a)					
	330.790a)					
	330.790c)1)					
-	Section 330.710 Res	aidant Cara Dallaia				
	C) The facility at all to	sident Care Policies				
	a) The facility shall n	ave written policies and				
	procedures governin	g all services provided by the				
	racility. The written p	olicies and procedures shall				
	be formulated with th	ne involvement of the				
	administrator. The w	ritten policies shall be				
	followed in operating	the facility and shall be		79777		
	reviewed at least ann	nually by the Administrator.			to as a second	
	The policies shall cor	mply with the Act and this		William Control of the Control of th		1
-	Part.					ŀ
	Section 330.790 Infe	ction Control		The state of the s		1
		dures for investigating,				
	controlling and preve	enting infections in the facility				
9	shall he established a	and followed. The policies				I
	and procedures chall	be consistent with and				
	include the requireme	ents of the Control of				
	Communicable Disas	ents of the Control of				l
	SOON and Control of O	ises Code (77 III. Adm. Code				
r	Discourse Control of S	exually Transmissible			and a	
	Diseases Code (77 III	. Adm. Code 693). Activities				
,	shall be monitored to	ensure that these policies		of Communi		I
	and procedures are fo			is defined and the second of t		
C	(c) Depending on the s	services provided by the		The second secon		
f	acility, each facility sh	hall adhere to the following				
9	juidelines of the Cent	ter for Infectious Diseases.				
C	Centers for Disease C	Control and Prevention.				- 1
L	Jnited States Public F	lealth Service, Department				I
o	f Health and Human	Services, as applicable				I
(9	see Section 330.340)	r				
		Hygiene in Health-Care			i de la companya de l	1
	ettings	1179ione in Health-Cale				1
. 0	- Curiga	nanas pras			V.	1
-	hie Doguiromant !	ot most so suids	and the same of th			
	ina requirement is n	ot met as evidenced by:				-
_						İ
В	ased on observation,	interview and record				

	ENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DAT	E SURVEY
			A. BUILDIN	G:		_
0		IL6015192	B. WING			C 23/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY	, STATE, ZIP CODE		
PPOOK	DALE HOFFMAN EST		ST GOLF R			
BROOM	COACE HOT I MAN EST.	O GOEL IND	N ESTATES			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN O	TION SHOULD BE	(X5) COMPLETE
			TAG	CROSS-REFERENCED TO DEFICIEN		DATE
S9 <b>99</b> 9	Continued From page	ge 10	S9999			
	review, the facility fa	ailed to follow their policy for	and produce of the second			
	hand washing and p	erineal care.				
	<b>T</b>	_				1
	reviewed for incention	f 4 residents (R3, R4)				The state of the s
0	4.	nence care in the sample of				
	The findings include	•				11110
ļ	1.) On September 2	3, 2015 at 12:32 PM, E6				
MILE - 1111	(RA-Resident Assista	ant) and E7 (RA) transferred				
The second secon	R3 from the high-bac	ck reclining wheelchair back				
	to bed, using the me	chanical lift. E6 and E7				
İ	provided incontinenc	e care to R3. E6 and E7				
1	denned clean slaves	with soap and water and				
T) color	pants and incontinon	. E6 and E7 removed R3's				
	was wet with urine	ce brief. E6 stated the brief E6 and E7 turned R3 onto his				
A PARAMETER	left side and used a d	disposable wipe to clean R3's				
	buttocks area. A dres	ssing was adhered to R3's				
The state of the s	coccyx area, with the	lower border loose and not				
	adhered to R3's skin.	E6 lifted the border of the				
	dressing to reveal a s	stage 2 pressure ulcer on				
	R3's coccyx." With the	ne same gloved hands. E6				
į.	and E7 applied a clea	an incontinence brief under				
	R3 and turned R3 ont	to his back. E6 and E7				
	removed their gloves	and donned clean gloves			**************************************	1
	williout washing their disposable wine to cle	hands. E6 used a new ean R3's bilateral groin and				
	scrotal areas F6 and	E7 applied the front of the				ĺ
ĵ	ncontinence brief for	R3 with the same gloved				
ŀ	nands. E6 and E7 rer	moved their gloves, and			and the second	
V	without washing their.	hands, repositioned R3 in				1
t	he bed, leaving his pa	ants down at his ankles. E6		•		l
a	and E7 pulled up R3's	blanket to his chin.				
g	gathered their belongi	ngs and then washed their				1
h	nands with soap and v	vater, before leaving the			discount of the second	1
r	oom. E6 said, "R3 is	unable to assist with any of				
。 i h	iis care. He is inconti	nent and requires our				
	ssistance with all care				de value :	ļ
S	Free facility's POS (phy September 1, 2015 for	/sician's order sheet) dated R3 shows diagnoses that				

Illinois Department of Public Health

	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
			A. BUILDING	):		
		IL6015192	B. WING _			C <b>2</b> 3/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
BROOK	DALE HOFFMAN EST	S GOLE PD 2150 WES	ST GOLF RO	DAD		
5,000.	DALL HOLL MAR LOL	HOFFMAI	N ESTATES	, IL 60194		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
S9 <b>9</b> 99	Continued From page	ge 11	S9999		W	
	include: dementia, aggressive frontal lo atrial fibrillation.	arthritis, incontinence, be aphasia, pacemaker, and				
	shows R3 is "totally understood, is sever makes decisions, re to and from meals, a areas, requires phys	lan dated June 4, 2015, confused, is rarely or never rely impaired: never or rarely quires assistance for mobility activities, and/or common ical assistance with brushing hing hair, washing hands and es assistance with sees mechanical lift."				
	(RA) and E8 (RA) us transfer R4 from the E6 said "R4 does no He cannot feed hims bathe himself. He is him up. He cannot gour help." Once R4 vE8 provided incontine washed their hands v donned clean gloves incontinence brief and During the cleansing observed to urinate a cleaned R4's bilateral scrotal area with a dishis gloves and donne without handwashing his right side. An area R4's coccyx area, as hear R4's right and leas small amount of broarea with a disposable clean R4's buttocks as	2, 2015 at 12:48 PM, E6 ed a mechanical lift to high-back wheelchair to bed. t talk, and he does not help. elf, or dress himself, or bedridden if we don't get et in and out of bed without was placed in bed, E6 and ence care to R4. E6 and E8 with soap and water and E6 and E8 removed R4's d cleaned R4's genital area. of R4's genital area, R4 was large amount of urine. E6 groin areas as well as the eposable wipe. E6 removed d a new pair of gloves E6 and E8 turned R4 onto a of excoriation was seen on well as two reddened areas ft gluteal folds. E8 cleaned wn stool from R4's rectal e wipe. E8 continued to nd between R4's legs with wipes. E8 removed the				

4VVQ11

STATE MENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY	
			A. BUILDING:		СОМ	C 09/23/2015	
		IL6015132			3		
NAME OF	PROVIDER OR SUPPLIER	STORETA	ODDECC CITY	STATE, ZIP CODE	1 091.	23/2015	
		24 50 14/5	ST GOLF RO				
BROOK	DALE HOFFMAN EST	3 GOLF RD	N ESTATES,				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES					
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ACTION SHOULD BE COMPLETE TO THE APPROPRIATE DATE		
S9 <b>99</b> 9	Continued From pa	ge 12	S9999				
	without performing handwashing. E8 applied		The second secon				
	barrier cream to R4	's buttocks. E8 removed her				NATION AND ADDRESS OF THE PARTY	
	gloves and donned	another pair of gloves, again				** PREADOOL S	
	without handwashin	g and placed a new					
	incontinence brief or	n R4 and a new incontinence					
	bed protection pad u	under R4 with the same	and the series				
ļ	gloved hands E6 ar	nd E8 removed their gloves	A CONTRACTOR OF THE CONTRACTOR			The state of the s	
	cathered their suppl	in the bed. Both E6 and E8 ies and washed their hands	The state of the s			and the state of t	
	with soap and water	. Incontinence care was				THE RESIDENCE AND A STATE OF THE STATE OF TH	
	completed at 1:00 P						
	•						
	The POS dated Sep	tember 1, 2015 for R4 shows					
diagnoses that include		de: vascular dementia with			THE RESIDENCE OF THE PROPERTY		
-	and behavior disturb	on, disorganized behavior,			000		
	and benevior distant	ance.	THE PERSON NAMED IN COLUMN NAM				
	R4's resident care pl	an dated September 1, 2015					
		orts resident via wheelchair,	Was a second				
	requires two-person		PORTAGE				
	patning/snowering.	R4 is totally confused, pod: staff interprets body					
	language mumbles	R4 requires physical assist					
2	with brushing teeth/d	entures, brushing hair,					
	washing hands and f	ace, shaving. Uses					
W - Mahampagan grass sa	sit-to-stand mechanic	cal lift for transfers."			W	l	
	D. 41					Ī	
	R4's care profile dated February 25, 2015 shows		in American		***		
	needs full assist with	shower requires a			semantic co	-	
	mechanical lift for train	nsferring during all transfers,				İ	
ŧ	uses a high-back recl	lining wheelchair for mobility,					
	and hospice services	•					
-	The facility's policy on	stitled "House, Head					
1	Vashing - Associates	ntitled "How to: Hand " revised June, 2014			,		
S	hows: "1. A minimu	m twenty (20) second hand			To the state of th	Ì	
v	vashing should be pe	erformed in situations			100 mm		
i	ncluding but not limite	ed to: Whenever hands are					
C	bviously soiled, after	handling used dressings,				İ	

IMPONS SEPARATION OF ABILITIES IN												
	MENT OF DEFICIENCIES  LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY						
AND P EAR OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		СОМ	COMPLETED						
			1			0						
IL6015192		B. WING			C							
			1		1 09/	23/2015						
NAME	OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STATE, ZIP CODE									
BROOKDALE HOFFMAN ESTS GOLF RD 2150 WEST GOLF ROAD												
HOFFMAN ESTATES, IL 60194												
(X4) II	O SUMMARY STA	ATEMENT OF DEFICIENCIES	7		DECTION							
PREF	X (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION		(X5) COMPLETE						
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE	DATE							
			- Table	DEFICIENCY)								
S999	Ontinued From pa	ge 13	S9999									
	tissues lines etc	atheters, contaminated										
	Care After contact	After offering incontinence with blood, urine, feces, oral										
	secretions mucous	membranes, or broken skin.	ar year									
	After handling items	s potentially contaminated with										
	any resident's blood	I, excretions, or secretions.	-			The state of the s						
	3. The use of alor	ves does not replace hand				Act and the second						
	washing."	The second residue of the second residue of				the tary						
		(B)				And the second s						
				The continue								
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